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One in three: challenging heteronormative assumptions in family planning health centers☆,☆☆,★

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ABSTRACT

Objectives: To estimate the prevalence of sexual-minority women among clients in family planning centers and explore differences in LARC uptake by both sexual identity (i.e., exclusively heterosexual, mostly heterosexual, bisexual, lesbian) and sexual behavior in the past 12 months (i.e., only male partners, both male and female partners, only female partners, no partners) among those enrolled in the survey arm of the HER Salt Lake Contraceptive Initiative.
Methods: This survey categorized participants into groups based on reports of sexual identity and sexual behavior. We report contraceptive uptake by these factors, and we used logistic and multinomial logistic models to assess differences in contraceptive method selection by sexual identity and behavior.
Results: Among 3901 survey respondents, 32% (n=1230) identified with a sexual-minority identity and 6% had had a female partner in the past 12 months. By identity, bisexual and mostly heterosexual women selected an IUD or implant more frequently than exclusively heterosexual women and demonstrated a preference for the copper T380 IUD. Exclusively heterosexual and lesbian women did not differ in their contraceptive method selection, however, by behavior, women with only female partners selected IUDs or implants less frequently than those with only male partners.
Conclusion: One in three women attending family planning centers for contraception identified as a sexual minority. Sexual-minority women selected IUDs or implants more frequently than exclusively heterosexual women.
Implications: Providers should avoid care assumptions based upon sexual identity. Sexual-minority women should be offered all methods of contraception and be provided with inclusive contraceptive counseling conversations.

1. Introduction

Sexual orientation is a multi-faceted construct that includes sexual identity, sexual behaviors, and sexual attraction (see Fig. 1). Many sexual-minority women (women who do not identify as exclusively heterosexual and/or whose behavior includes same-sex romantic/sexual relationships) have had sexual relationships with men [1]. For example, nationally representative data show that bisexual-identified women report an average of 17.6 lifetime male partners and lesbian-identified women had 2.9 male partners [2]. Sexual-minority women also have an increased risk for unintended pregnancy and sexually transmitted infections (STIs) compared to their heterosexual peers [3–6]. Little research, however, has explored 1) the prevalence of sexual-minority women, as determined by sexual identity and behavior, among clients attending family planning centers; and 2) sexual-minority women's contraception uptake, and specifically long-acting reversible contraceptives (LARC) uptake.

Improving knowledge regarding the sexual-minority client population in family planning centers is important for addressing the elevated risks for unintended pregnancy and STIs among sexual-minorities for several reasons. First, providers may assume that women accessing sexual and reproductive health services, especially family planning-related services, identify as heterosexual or are in exclusively opposite-sex sexual and romantic relationships [7–10]. Across studies, women report this assumption of sexual orientation and behaviors to be

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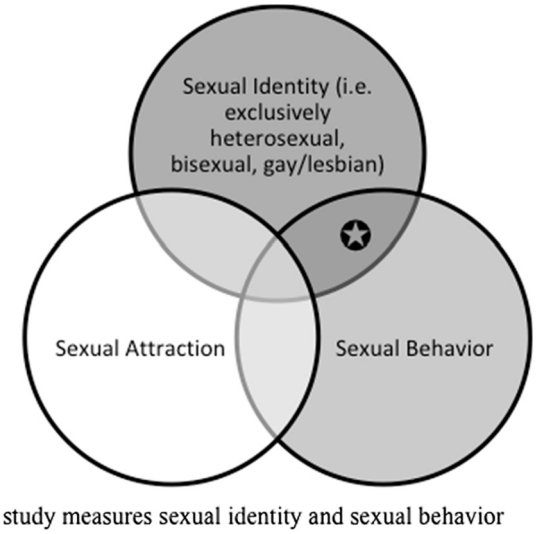

Fig. 1. Dimensions of sexual orientation.

problematic, in part because of the burden it places on women to disclose their orientation in a context that may not be perceived as safe (i.e., where they will not be discriminated against) [8,11]. Second, sexual minorities may believe that their care providers are not adequately prepared to provide them with accurate sexual health information. Some sexual-minority women report instances where they disclosed their identity and/or sexual behaviors and were then advised that they did not need to consider important reproductive health services, such as STI screens [7,8,12]. Such negative interactions with healthcare providers in clinical settings serve as a deterrent to seeking care among sexual minorities [7,13,14]. Third, although ACOG has issued formal statements and guidelines for how to treat lesbian, bisexual, and transgender (LGBT) individuals [15,16], a lack of LGBT-focused training in clinical health sciences educational programs often results in low levels of cultural competency among providers working with sexual minorities [7,9,17]. While gender minorities (i.e., transgender men, genderqueer individuals, and others whose gender identity does not correspond with their assigned sex at birth) are also an understudied and underserved population, this paper is about the relationship between sexual-minority women and method choice and does not address the role of gender identity.

By providing data on the prevalence of sexual-minority women and their patterns of contraceptive uptake in family planning centers, this study challenges heteronormative assumptions about *who* visits family planning health centers. Additionally, we are interested in client prioritization of contraception methods in an environment with client-centered counseling across sexual orientations.

2. Methods

2.1. Data

Data come from the survey arm of the HER Salt Lake Contraceptive Initiative (HER Salt Lake), a prospective cohort study nested in a quasi-experimental observational study [18]. The primary objective of HER Salt Lake was to assess method use (both uptake and method switching) when cost and access barriers were removed in an environment with client-centered counseling. A total of 11,509 unique individuals presented for new contraceptive services at HER-participating health centers between September 28, 2015 and March 25, 2017; 4425 (38%) of these clients enrolled in the survey arm of the HER Salt Lake study. We recruited participants from four family planning health centers in Salt Lake County. Three of these locations were Title X health centers and one location provided abortion care. The cohort described in this manuscript includes survey-arm respondents who 1) engaged in contraceptive counseling conversations; 2) were between ages 18 and 45; 3) responded to the one-month follow-up survey; and 4) answered the sexual identity and behavior measures. Contraceptive counseling conversations were guided using 10 evidence-based best practices [19]. The 10 best practices were based on a shared decision-making model that centered the client's personal values, culture, and life experiences and were initiated across health centers as standard of care before the start of HER Salt Lake. Participants enrolling in the first 6 months of the study September 28, 2015-March 27, 2016 (control period) received standard of care (sliding fee scale based on Title X benefits and ability to pay) with regards to paying for their services, and participants enrolling in the last 12 months of the study March 28–September 25, 2016 (first intervention period) and September 26, 2016–March 25, 2017 (second intervention period) received their preferred contraception at no cost. The second intervention period included an online media campaign intended to increase awareness of the study.

2.2. Measures

We employed a brief enrollment survey to minimize delays in clinical care, thus the first assessment of participants' sexual identity and behavior occurred at the 1-month follow-up survey. Participants chose from five categories to identify their sexual identity: "exclusively heterosexual" (referent), "mostly heterosexual", "bisexual", or "mostly/exclusively gay or lesbian" (referred to as "lesbian" from here on), or other/unknown. Participants who selected "other or unknown" (n=6) were excluded from the analyses.

The sexual behavior measure captures whether the participant reported only male sexual partners (referent), both male and female sexual partners, only female sexual partners, or no sexual partners in the past 12 months. We did not assess the number of partners or types of sexual behavior. Several survey items assessed at enrollment addressed sexual and reproductive history. These included whether participants had ever been pregnant (1 = yes, 0 = no), ever had an abortion (1 = yes, 0 = no), and if they had unprotected intercourse (UPI) in the past two weeks (1 = yes, 0 = no). In the enrollment survey, participants reported all previously used forms of birth control. From this we created a dichotomous measure of previous IUD or implant use.

The contraceptive method a participant left with was derived from a survey question that listed all the forms of contraception provided at the sites. If participants reported more than one method, responses were coded based on the most effective method. The first contraceptive method variable measures whether the participant selected an IUD or implant or another less effective method (1 = LARC method, 0 = non-LARC method). A second measure categorized participants as selecting combined oral contraceptive (COC) (referent), implant, Copper T380 IUD, hormonal IUD, or depot medroxyprogesterone acetate (DMPA). Due to small samples sizes, we excluded women who selected other forms of contraception (condoms only, patch, ring, progestin-only pill, diaphragm, emergency contraception, or fertility awareness methods) from this analysis.

We adjusted for several factors that may influence method selection. We coded age as a categorical variable: ≥18 and<20 (referent); ≥20 and<25; ≥25 and<30; or≥30 and<35; or≥35. Race/ethnicity codes included white (referent), Latina, or other race/ethnicity. Insurance status was coded no insurance (referent), public insurance including Medicaid or Medicare, or private insurance. Income classifications derived from enrollment survey responses for self-reported annual household income and number of dependents included<100% below the federal poverty level (referent); ≥100% and <200%; ≥200% and <300%; or ≥300% the federal poverty level. Additionally, we controlled for enrollment period, since control period participants received standard of care with regard to their payment, whereas first and second intervention period enrollees received their contraceptive services and method(s) at no cost.

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